# Clear Resolutions Inc.

**An Independent Review Organization**
**6800 W. Gate Blvd., #132-323**
**Austin, TX 78745**
**Phone: (512) 879-6370**
**Fax: (512) 519-7316**
**Email: resolutions.manager@cri-iro.com**

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** May/06/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** bilateral L4-5, L5-S1 facet injection

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

**REVIEW OUTCOME:** Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ X ] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.** It is the opinion of the reviewer that the request for bilateral L4-5, L5-S1 facet injection is not recommended as medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The patient tried to catch a falling object and felt a pop in his back. Lumbar MRI dated 07/25/13 revealed at L4-5 there is a diffuse circumferential disc bulge; focal increased T2 brightness at the central/left paracentral annulus consistent with annular fissure and/or annular tear. Spinal canal is minimally narrowed. The left L4-5 neural foramina is asymmetrically narrowed. There is moderate facet hypertrophy present. At L5-S1 the disc is well hydrated and well-maintained. The spinal canal and neural foramina are well-maintained. There is mild facet hypertrophy. The patient underwent lumbar interlaminar epidural injection on 11/08/13. Follow up note dated 12/13/13 indicates that he is still working regular duty but has a lifting restriction. Follow up note dated 01/16/14 indicates that he no longer has leg pain as it resolved with the epidural steroid injection. Physical examination on 01/16/14 indicates there is tenderness to palpation over L4-5 and L5-S1. There is pain with spinal extension. Deep tendon reflexes are 2+ bilaterally. Sensation is intact in the lower extremities. Progress note dated 02/04/14 indicates that the patient has completed 2 physical therapy visits, and has had multiple no-shows and cancellation of appointments.

Initial request for bilateral L4-5, L5-S1 facet injection was non-certified on 02/14/14 noting that given his prior exam findings, multiple pain generators, MRI findings it is unlikely that a facet injection would be of any significant long term benefit. The denial was upheld on appeal dated 03/19/14 noting that the claimant carries a diagnosis of lumbar raid and has had a positive response to a lumbar epidural steroid injection. Lumbar radiculopathy is a contraindication for lumbar facet injection.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on xx/xx/xx. Progress note dated 02/04/14 indicates that the patient has completed 2 physical therapy visits, and has had multiple no-shows and cancellation of appointments. The Official Disability Guidelines require documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. As such, it is the opinion of the reviewer that the request for bilateral L4-5, L5-S1 facet injection is not recommended as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

**[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

**[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

**[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

**[ ] INTERQUAL CRITERIA**

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

**[ ] MILLIMAN CARE GUIDELINES**

**[ X ] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

**[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

**[ ] TEXAS TACADA GUIDELINES**

**[ ] TMF SCREENING CRITERIA MANUAL**

**[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**